August 23, 2013

Mr. John McGarry
President and Chief Executive Office
Horizon Health
PO Box 9000
Fredericton, NB, E3B 5N5

Dear Mr. McGarry,

I am a retired nurse. I am proud of what nurses can do to care for patients across the lifespan. I have chosen to write the attached report, "Carl Ericson's Last Class", to honour the work that nurses perform and to support the need for improvements in the Health Care System that will allow them to provide competent care.

Carl was a professor at UNB for his career. He wanted students (family and friends as well) to explore and understand why certain decisions were made, as well as the consequences. I am requesting that the attached document be used to explore and understand decisions that have been made in the acute care setting and how they can be improved. That is why I have used the title, "Carl Ericson's Last Class". Hopefully, the experiences he and his family had will be useful tools for Horizon Health and the Department of Health to use in developing new priorities for improving nursing care for all patients.

Carl was admitted to the Dr. Everett Chalmers Hospital many times. Three admissions alone added up to 365 days of care! Therefore, this is not the first time that I have had ideas for improving nursing care, but it is the first time that I have made the time to share my observations, experiences, and recommendations based on the care my late husband received during his seven month stay at the Dr. Everett Chalmers Hospital. I have serious concerns about the environment in which nurses are expected to practice and the negative consequences that patients experience.

There were many examples of good care from professional staff, housekeeping staff and office staff. However, it will not benefit them if the short comings in the system are not addressed because the current environment is difficult for them to function in professionally.

Our family's consolation at the end of Carl's time in the hospital was that three of our "favourite" nurses were working. They did care and they did make a difference,not just to Carl, but to me. I am asking YOU to make a difference to the nurses who come to the hospital every day, hoping to provide good care, but who are unable to because they are not listened to, not supported in their professional growth, and/or not supported with enough staff to meet practice guideline

I will be visiting with our daughter in the United Kingdom for most of the month of September. I will return to Fredericton on 29 September, 2013. If you wish to meet with me or seek further clarification, I may be reached by calling (506)458-5519 or e-mailing: pkericson@iCloud.com.

Thank-you very much for reading this report. It will be a demonstration of your commitment to the points articulated on the Horizon Health webpage.

Penny Ericson

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The New Brunswick Nurses Union
The Faculty of Nursing, UNB

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EXECUTIVE SUMMARY

Primary nursing was the staffing model selected when the DECH was opened. It reverted to "almost" Team nursing. Nursing care is always delivered as a team, but there needs to be an identifiable "head nurse" who the responsibility for the care of all the patients on that unit as well as the performance of the staff on a unit. The senior clinical position is delegated to other registered nurses when the shifts change. On units where the staffing is problematic, the transfer of clear communication about patient care issues and staff issues becomes less than acceptable. The nurse in charge of a unit needs to have a consistent presence on the unit to demonstrate the knowledge of and passion for quality care for this position to be effective. She/he needs to know that administration will support her/him and their staff in building strengths where weaknesses are identified. The staffing model currently used does not allow for continuity of care, safe decision making, or positive patient outcomes.

Many of the problems identified in this document are relatively easy to correct and should not present significant cost factors. However, changing the requirements for senior clinical/head nurse positions will have cost implications. The pattern of part-time help is also a cost issue. Both of these cost items need to be evaluated in terms of safe patient care.

Page 9 on the Horizon Health Web page discusses improvement strategies to be measured by the Lean Six Sigma process. It is stated that one of the goals will be to "standardize Nursing Staff levels to ensure greater patient care by reducing variability in unit coverage". Achieving that goal will help to diminish the care problems within the current staffing arrangement IF and ONLY IF the care required by the patients on each unit is assessed on an on-going basis by qualified professional nurses and a consistent staff. Licensed practical nurses and personal care workers are valuable assets to the care team, but they require qualified leadership to help develop the best care plans possible for each patient. The danger in borrowing assessment tools, such as Lean Six Sigma, from corporations such as Motorola, is that the tools work effectively for many types of scheduling and ordering and standardized procedures. However, patient care is NEVER standard. One Parkinson's patient with dementia and stroke is NOT like another one. There has to be skilled leadership to help with the daily assessment and planning of patient care in order to use the word Quality and Respect appropriately. It is my hope that this document will assist with your goal to provide quality care to all patients within the Horizon Health system.

A Suggested Framework for Reading "Carl Ericson's Last Class"

The Horizon Health on-line documents have been used as guides for presenting information in this case study of one patient's care. The Disclosure Policy indicates that Administration and appropriate staff wish to learn about harmful or near miss events that occur. This document has been assembled as a learning/teaching tool, NOT as evidence for litigation. The only outcomes that are desired are changes in the system that will allow for enhanced professional care.

The statement on Quality encourages the recommendations made within this document. The professional standards for nursing practice, clearly stated by the Nurses Association of New Brunswick documents, also support the recommendations made within this document. The challenge for the New Brunswick Department of Health and Horizon Health is to implement them.

Strategic Directions presents laudable goals which are currently impossible to achieve with the staffing plan utilized. The Enabler of the Horizon Mission identifies under People Readiness a goal to develop and align leadership talent to drive execution of Horizon Strategy. The examples in this document clearly illustrate the need for professional leadership. The system in place does not support professional leadership nor does it support professional growth.

The Values of compassion, respect, integrity, collaboration, excellence, sustainability and innovation are laudable, and there are examples in this report of these values, but the system does not support them. The values were demonstrated by individuals rather than by staff as a whole.

The Situation

Carl Ericson was a patient at the Dr. Everett Chalmers Hospital from July 9, 2012 until his death on February 10, 2013. He was admitted from home through the Emergency Room with presenting symptoms of a stroke. This health diagnosis was added to his health challenges from Parkinson's Disease and related dementia. Following assessment in the ER, he was admitted to 4NW. He was transferred from there to 3NE on July 23rd, and after their assessment was completed, he was transferred to 4E on September 3rd.

During his hospitalization, his family kept a journal of his activities, visitors, achievements and care. It was a rare occurrence for Carl to be left alone during visiting hours. If I was not able to be with him, he had another family member or close friend with him to cover lunch,nap, supper and evenings until bedtime. The comments in the journal also included the insights of nurse friends as well as lay friends who knew Carl well.

The following report has been written as a teaching tool as well as a report to highlight the need for changes. Carl was a teacher. It is a hope that this "last class" will teach those in administrative positions to make changes that will be consistent with the goals of Horizon Health.

There were many examples of good care during Carl's hospitalization, but this report's focus is on the short comings observed by those involved. The report has been written in the best interest of providing constructive criticism that may lead to enhanced patient care.

GOLD STARS

It is important to congratulate those in the hospital who added competence and joy to our experience. I will comment at this point solely on the individuals who are staff - rather than the professional staff. Four individuals are at the top of my list: Lynn Williams in the Cashier's Office in the entrance lobby. During the months that I was paying for part of Carl's care on 4E, I "paid my dues" to Lynn. One statement arrived with an additional $2,000+ dollars added to it. Lynn looked at the bill, thought through what it might be, called the appropriate person in the finance office, and let me know that it was the double room charge. Because Carl was admitted via the ER and I never filled out the paperwork in Admissions, this had not been covered by his UNB insurance. The problem was quickly and efficiently resolved.

The second person who gets a gold star is Paul Young. He would deliver laundry to the floor and sometimes the food carts. He knew Carl from the years when he used to work at the Co-op. He was always cheerful and gave Carl a big "Hello" in his best Newfoundland voice. He recognized Carl as a "real person" - not simply as a patient waiting to go to a nursing home to die.

The third person who earned a gold star is Joan Manderson in the Lobby Cafe. We went there most days from 3:30 - 4:30 for a coffee and treat for Carl. Friends would stop by and join us. Joan always made sure that Carl had his coffee double-cupped so that he wouldn't burn himself, and she always made sure that he had a paper plate to put his "two bite" brownies on once the package was open. If I wasn't the one accompanying Carl, she would always make sure that the "routine" was followed.

The last gold star goes to the substitute Activity Director on 4E, Melissa Martin. She was the sunshine on 4E who spent her days trying to engage the patients in activities that would strengthen their abilities and provide diversion from the routine. She started making biography poster boards to put above patients' beds so that staff would know something about the individuals before health challenges had diminished so many of their strengths.

Summary of Environmental Issues

1. **Problem:** *Cleanliness of floors.*

   Example: "Zamboni's" effectiveness hampered by clutter in halls.

   Solution: Coordinate housekeeping staff's appearance on unit before Zamboni to clear hall and then to replace items.

2. **Problem:** *Laundry on floors.*

   Example: bed linen and patient laundry deposited on floor during care.

   Solution: bring laundry hamper into room during care and return to hall when care completed.

3. **Problem** *Proper cleaning of patient clothing, including shoes.*

   Example: Carl's shoes and clothes were cleaned at home.
   Non-Fredericton residents' clothes/shoes were cleaned on the unit.
   How does this meet standards for killing contaminants?

   Solution: Set a standard for meeting contaminant containment and provide this information to family members who are expected to clean patients clothes at home using non-industrial products (if this is possible in light of C-difficile and other hospital contaminants.)

   Problem: *Cleanliness of Bathrooms.*

   Example: Bathrooms between bedrooms are too small for patient use when patient requires staff and equipment to use the facilities. They are also too small for easy cleaning.

   Solution: Create space for another bathroom on the unit that will accommodate transport devices and staff supporting the patient. This would then be large enough for proper cleaning.

5. **Problem**: *Proper cleaning of ventilation systems in patient rooms.*

   Example: The ceiling vent was so occluded with dirt and dust that it wasn't able to exchange air.

   Solution: Increase cleaning schedule from once a year to at least twice?

6. **Problem:** *Improper cleaning and labeling of patient bedside tables.*

Example: The sides and undersurfaces of the bedside tables were never observed to be cleaned. The sides and undersurfaces of cafeteria tables were never observed to be cleaned.

Solution: Educate personnel to clean the sides and undersurfaces of dining tables and over bed tables - surfaces that patients and visitors use constantly. Labeling a patient's over bed table with his/her name might help prevent cross-contamination.

7. **Problem:** *Use of the over bed table as a stand for urinals.*

Example: Staff encouraged patients to use the over bed table for easy access. Unfortunately, this same surface is where their meals, snacks, and other personal items were placed.

Solution: Place the urinal in the bedside table - or if the patient requires it on "short notice" - keep it beside him in bed.

8. **Problem:** *Best use of the sink in the patient rooms?*

Example: Care staff view the sink as "dirty" despite the fact that housekeeping seemed to clean it regularly. Patient's lotions and treatment creams and mouth care products are frequently kept on this surface. Suction equipment and oxygen equipment are kept on this surface.

Solution: Establish a consistent protocol for the use of this area.

9. **Problem:** *Attention to basic personal care.*

Example: Carl required two sets of glasses in order to see properly. He had a dental bridge for a front tooth that was important for him for cosmetic reasons as well as chewing. These were rarely used correctly.

Solution: Place a card in a consistent place in the patient's unit so that care staff will be informed of what is special for this individual's personal care.

10. **Problem:** *The efficacy of wearing face masks to prevent spread of "the flu".*

Example: The rationale for recommending face masks during flu season was inadequately explained and inconsistently managed.

Solution: The need for a better understanding of infection control within the hospital is crucial. Administration and staff need more education and monitoring to make the hospital a safe place to work and to receive care.

Equipment Safety/Patient Safety

11. Problem: *The wheelchairs that Carl was required to use were in poor repair.*

Example: The wheelchair he was assigned on the stroke unit had a foot rest that dragged on the floor. The wheelchair that he was assigned on the rehab unit had tires that were so worn that the brakes didn't work.

Solution: Improve vigilance on maintenance for patient safety.

12 Problem: *Bed monitors are required for patients who try to get out of bed or a wheelchair when they don't have the capabilities to do it safely. The bed monitor needed to be repaired on Carl's bed.*

Example: Carl's bed monitor broke and he had to wait two days for a replacement monitor to be found in the hospital. This is not a problem unique to the Transitional Care Unit. Care was not provided with a bed monitor when he was a patient on Orthopedics awaiting repair of his broken hip. Pain medicines confused him and he managed to crawl "off the sinking ship", and he fell off the bed to floor. He was in a private room and had to holler for a nurse for a lengthy period of time before help came.

Solution: Provide more monitors for the patients whose safety is not reliable without one.

Nutrition and Diet

14. Problem: *Obesity is a national problem and a contributing factor to many illnesses. Food sold on the units and food available to patients in the ward kitchenettes did not represent healthy choices.*

Example: Chocolate bars are sold on the Stroke Unit for staff, patients, and families. Peanut butter is liberally used in a hospital that frequently has to care for patients who are severely allergic to not only eating the substance, but smelling it.
Evening snacks are served on 4E and these are usually extra desserts. Added sugar at bedtime is rarely an asset.

Solution: Refrain from supporting "worthy causes" that sell chocolate bars. Provide items on the patient units that are positive nutritional choices. Use the televisions in waiting areas (ER, X-Ray, etc.) to provide good nutritional information to the public.

15. **Problem:** *Nutritional support to the Transitional Care Unit is not adequate to meet the needs of the patients and staff.*

Example: Parkinson's Disease caused serious swallowing issues for Carl. He was at serious risk for aspiration and needed to be treated for the occurrence. He was able to eat small amounts at a time. High protein drinks were ordered and given by staff at mealtimes. This depressed his appetite and reduced his caloric intake.

Solution: Protein drinks and mid meal snacks should be given between scheduled meal times, not at meal times.

Communications

16. **Problem:** *Bulletin boards are not used effectively.*

Example: The bulletin boards on the patient units should provide patients and families and visitors with accurate and up to date information. Bulletin boards are not always up to date and some rarely changed.

Solution: Bulletin boards are an important means of sharing health information. If staff is too busy to keep them up to date, share the opportunity with health agencies in the Region that support targeted health issues. Inviting the university to share new research in targeted areas is another suggestion.

17. **Problem:** *Communication between the family physician and the specialist needs to be improved.*

Example: The doctor assigned to Carl on 3NE did not consult with the family physician about the dosage of Sinemet that Carl was taking. The specialist decreased the order, and the negative side effects were immediate and not rectified for several days, despite my protests and the nurses' assurances that the issue had been raised.

Solution: Specialists and family physicians need to develop a better communication structure to prevent mismanagement of care.

18. **Problem:** *Communication of the uniqueness of the Transitional Care Unit needs to be delivered to families more effectively.*

Example: On the day that Carl was transferred to 4E, I was informed about the pay schedule, the fact that it was a locked unit, and that I was welcomed to use the kitchen for juices or food for Carl. I was not told that I was entitled to a parking pass nor was I informed that I was responsible for Carl's laundry.

Solution: The uniqueness of the Transitional Care Unit needs to be explained in a brochure that is given to family members when they arrive on the unit.

19. **Problem:** *The factors determining a family member's presence in the dining room were not consistently followed.*

Example: I was told that I shouldn't go to the dining room with Carl because the facility was crowded and the nurse assigned to the room had to be able to reach patients quickly if they were in distress. I was told to stay in the dining room to help Carl because he ate slowly and he was at risk for aspiration.

Solution: Establish a policy for patients whose families are consistently there at lunch and supper time so that we know what is appropriate. It also needs to be constructed to be best for the patient.

20. **Problem:** *The caregivers in the hospital are not clearly identified. Name tags are not visible and the white boards are not filled in properly for each shift.*

Example: The plastic identification cards that serve as entry cards to the unit and medication room are too small to read and are usually carried inside a pocket for safety reasons. Name tags with the nurses' names and credentials are not used. This is totally unprofessional, from my point of view. Any care worker should be identifiable to the public they serve - for reasons of praise as well as reasons of censure. The white boards in each room were rarely kept up to date with the accurate staff.

Solution: All staff should wear name tags that printed so that they can be easily read, and they should state the care givers' credentials. White boards should state who is working each shift.

21. **Problem:** *The communication of changes in orders is not managed well. Confusion causes failures in adequate patient care.*

Example: Dr. Christie moved Carl to a status of palliative care. Carl was moved to a private room. The orders stated that he could have nothing by mouth. Communication of what it meant to have Sinemet removed from his system was not explained nor understood in a way that allowed the nurses to provide adequate care. Medications were delayed and orders for comfort measures (such as an indwelling catheter) had to be initiated by Carl's wife.

Solution: End of life care on 4E is not an uncommon occurrence. The staff try to be helpful and caring but they are not provided with appropriate information to sustain competent care. A few of the nurses understood what needed to be done and why, but the transmission of this important information evaporated between shifts and reports. There need to be better methods put in place to itemize essential care strategies for patients on 4E.

22. **Problem:** *One of the major problems that occurs on 4E is the end of shift conversations that take place within the Nursing Station and the conversations that occasionally occur in the dining room when more than one staff member is there. The conversations are frequently inappropriate for public spaces.*

Example: Six of the nursing staff on 4E were assembled at the nursing station at the end of the day shift and discussing the difference between nursing care on 4E and a nursing home. One of the care staff stated that the care between the two was not dramatically different except that you could give patients more drugs at the nursing home to help them die. The person who was caring for Carl was seated at the window in his room, and she walked out to the nursing station and suggested that the conversation be changed and that the voices be lowered because she heard every word and the elderly husband of the woman patient in the next room was sitting by the door and probably heard the same thing.

Solution: The solution is complex because it involves far more than telling care staff not to discuss patient issues in public spaces. It also involves the Hospital Administration's attitude toward patients on the Transitional Care Unit. It is frequently discussed in public that the patients on this unit are preventing individuals with acute care needs from getting the required hospital beds. It is also translated less positively to the term "bed blocker". There has to be a shift in the attitude toward the individuals whose care has been judged no longer "acute" but whose care still requires professional care.

Family members and patients alike feel the stigma of "wasting valuable space". I would frequently ask the staff if they knew what an individual patient had done in the community when they were well - or if they knew who the family member was who came in religiously to help with a relative's care (a fact which also relieves the staff's workload). Staff does not know who the patients are because they are not encouraged by nurse managers/clinical experts to appreciate the value in understanding the individual rather than simply caring for the physical shell of an older person. The other issue that arises on the Transitional Care Unit occurred in Carl's case. When his physician changed Carl's orders to palliative care there was no change in the expertise afforded Carl. Would his last week of life been more comfortable if he had been transferred to the Palliative Care Unit? There were more than a few patients on 4East who never made it to nursing homes. Should their final days have been described by family physicians as palliative and should the patients then been afforded the expertise that is promulgated by the Palliative Care Unit?? Where is the respect, integrity and quality of care discussed on the Horizon web pages???

Summary of Professional Issues

1. **Problem:** *The current staffing plan, which maximizes part-time help and non-RN staff, requires a registered nurse in charge who is knowledgeable about the care of the patients on the unit and able to provide the leadership to the staff to provide competent care. This is not the case on the units where Carl was a patient. In defense of the nurses placed in the current role of leadership, their responsibilities keep them away from the patients and staff for too much of the day.*

   Example: The expanded text at the end of this document provides many examples of care that were not appropriate. Under the topic of Communications, read #5; under the topic of Professionalism, read #2,3,4; under the topic of Medications you may read #1,2, and 3.

   Solution: The nursing staff needs to be supported with knowledgeable leadership. These positions are crucial for the benefit of the staff working with them and for the ultimate quality of care that patients receive. The responsibilities for the Nurse in Charge should focus on the quality of care that patients receive and the continuing education (including orientation to the unit) that the staff requires in order to provide that quality of care.

2. **Problem:** *Medication errors are inevitable, but the current order book for medications and the cart for storing medications are antiquated and need to be updated for time management reasons as well as patient safety. There did not appear to be a pharmacist assigned to the Transitional Care Unit. This is a "last chance" for a medication review before a patient leaves for nursing home care.*

   Example: Medications are frequently administered in the dining room for efficiency and timing reasons. However, one of Carl's drugs caused hypotension if administered on an empty stomach. Breakfast was the time of day when he needed to receive the medicine after eating. The communication of this information was not simple, and Carl experienced several hypotensive episodes before the medication was adjusted.

   Solution: Modernize the medication administration system and utilize a pharmacist, in conjunction with the family physician, for assistance as patient conditions change. Utilize the knowledge of the care giver from home.

3. **Problem:** *It is important for nurses to question medication orders if they don't understand them, but it is inappropriate for them to withhold medications without proper consultation.*

Example: Carl's family physician had ordered Morphine Sulfate for foot pain. Carl had had gouty arthritis for 50 years, as well as surgery to correct foot problems ten years before his admission to 4E. When Carl walked - even when he was only "walking his wheelchair", his feet were walking bone-on-bone. It was not uncommon for his feet to scream "ouch" and he required a pain med. Tylenol was not effective. However, the nurses occasionally would doubt the veracity of the order of Morphine Sulfate for foot pain and refuse to bring it. I would have to explain and insist.

Solution: Pain control is an important part of patient care. If medications work or don't appear to work, the nurse needs to consult the physician. It is also helpful to ask the family caregiver if he/she knows why a particular drug is ordered rather than another.

4. **Problem:** *The absence of a senior, competent nurse whose main responsibilities were patient care and staff education meant that patient care was sporadic and frequently incompetent.*

Example: Individual nurses assessed Carl's problems, looked for possible solutions, implemented them and evaluated the outcomes. However, the communication of the changes was haphazard or non-existent. A senior nurse would have guided the whole staff to understand the reasons for the changes.

Solution: Hire senior nurses who are committed to the improved care of the patients on the units Carl used. Construct their job descriptions so that their primary responsibilities are to the patient and the education of staff to provide competent care.

5. **Problem:** *The "optics" of staffing are not ideal.*

Example: Providing nursing care for seniors who have some type of dementia as well as serious physical challenges requires nurses to be detectives as well as knowledgeable. The work is physically and mentally challenging and draining over a twelve hour shift. It is understandable that nurses want to relax, but the nurses station is not where the nurses should go to relax. There is a lounge for the nurses on the unit and they should use it. There have to be nurses at the station to answer call lights and maintain care during shift changes. However, it is not ideal for family members to be told that a patient needs to wait for 20 - 30 minutes for shift change before a

medication can be given, a trip to the bathroom can be accomplished, or a move from chair to bed can be made. There seems to be a general lack of understanding on the part of the staff that it is also "hard work" for a family member come to the hospital for 7 months to watch a loved one deteriorate and to see that person wait uncomfortably for help.

Solution: Request the nurses who have completed the assigned care to go to to take turns at the nursing station before the shift actually changes and to be prepared to assist patients when they need care. Nurses who are not required to be with their patients could sit in on report and perhaps improve the level of communication about patient care.

7. **Problem:** *The use of part-time staff (cost saving?) and shifting of staff between units is deleterious to patient outcomes and staff morale. For staff that doesn't move to other units, there is always the responsibility to bring "new" staff up to speed on patient changes. This is not safe.*

Example: A nurse from palliative care was transferred for a shift to 4E. He was not familiar with Carl's care nor with his ability to urinate. When a care giver explained to him that Carl was distended and needed a catheter, the nurse wasn't aware that Carl was on a palliative care regime, that he wouldn't be able to urinate on his own again, and that an indwelling catheter was the proper catheter to use. Consequently, he called the physician on call and asked for a straight catheter. This meant that Carl had to be catheterized again - a less than pleasant experience.

Solution: The benefits of a staffing mix that has a majority of full time employees would help to reduce the incidences of poor quality care, especially if they were able to work with an enthusiastic, competent, professional nursing leader.

Details of Environmental Issues

1. Carl entered the hospital through the emergency room. While he was in X-ray, my friend (a cleaning lady with years of experience at UNB and in private homes) and I watched the "Zamboni" driver clean the center of the corridor in front of us. He was followed by another housekeeping person who had a string mop and bucket to clean the floor in the utility room across from us. This person also used a brush to clean the sink and used a cloth to wipe the taps. After they left, I took a package of Kleenex from my purse and wiped under the linen hamper and supply cart in the hallway and used another Kleenex to wipe around the faucets in the utility room. Both tissues were dirty. Perhaps the utility carts are moved out from the wall daily, and perhaps the sinks are given a proper scrub daily - but residue on the tissues was substantial.

2. The driver of the "Zamboni" is challenged to clean the whole floor on the units because of laundry hampers, wheelchairs, med carts, and Geri chairs hugging the walls as well as patients sitting by the nurses' station. If the cleaning schedule was established, the corridors could be cleared by use of patient rooms, dining rooms and activity rooms.

3. Laundry Hampers present a challenge. Currently, the hampers are placed in the halls between patient rooms. Staff who bathe patients in the their rooms or change linen on beds simply throw the dirty linen on the floor and then scoop it up and carry it to the hamper in the hall. The staff was consistent in wearing gloves before providing direct care to Carl or his roommates - but then they would scoop up the dirty linen and hold it against themselves until they deposited it in the hampers. Their hands may have been clean, but their uniforms were contaminated regularly. In a hospital where infection is a problem, this could be remedied by having the staff educated to bring the hamper in to the patient's room when care is being given and have them put the necessary items in the hamper as they are removed from the patient or bed. This would prevent the large bundle growing on the floor - and prevent contaminants from staying on the floor and being tracked around on everyone's feet.

4. Because Carl and I had a home in Fredericton, I was asked to take his soiled clothing home and wash it. Both 3NE and 4E encourage patients to dress in their normal clothing during the day. I was willing to do this. However, patients who didn't have families coming in daily would have their laundry done on the unit. Again - I raise the question of contamination because I am not sure that non-industrial washing machines can clean clothes that might be soiled with materials that might resist the cleaning products. I was asked to take Carl's shoes home on a couple of occasions to clean them properly because of feces that fell on them during transfer from wheelchair to toilet. If they couldn't clean them properly at the hospital - what happened to the shoes of patients who didn't have families who would take them home and carefully clean them?

5. The bathrooms are a majestic challenge. They are SMALL. When Carl required two staff to help transfer him from wheelchair to toilet, it was a juggling act to safely achieve the task. Once he had finished using the toilet, the staff would then be challenged to properly clean him before returning him to his chair. The size of the bathroom is one excuse for not maintaining proper cleaning procedures. The floor and sink were frequently used for discarded linen and clothes. Once the patient had left the bathroom, no one cleaned the floor or sink after the contaminated linen was removed. The bathroom was shared by four people. There is not a string mop in the world that will properly clean a floor. The accumulation of filth that is glued to the corners and crevices of the bathrooms is horrendous. Perhaps the solution used to wash the floor has a strong disinfectant in it, but if so, it would be challenged to penetrate the build-up.

6. During late summer, two cleaning persons arrived. One had a clip board and the other had a vacuum cleaner. Their goal was to vacuum the vent in the ceiling above Carl's bed to get the room ready for heat exchange during the winter months. The grill above his bed was so clogged with dust that I didn't realize that it was a grill. They quickly vacuumed it and left to do the next room. The debris that missed being vacuumed, but was dislodged by the vibration of the grill, fell on to Carl's bed. He was up in his wheelchair by the window - so I simply changed his pillow case on the bed and his top sheet. I'm not sure that occurred in other rooms, nor am I sure that cleaning a vent twice a year (or once?) is sufficient. Perhaps the world has forgotten Legionnaires' Disease.

7. The bedside table and over bed table are cleaned by housekeeping and some care staff, but the rigor is lax. In my 7 months of being in the hospital cafeteria, the Lobby Cafe, and on three units, I never saw a person clean under the edge of a table. Many patients and visitors move a table or use it for support. Their hands frequently grip the table on both the surface and the undersurface. Tables and over bed tables frequently get moved when a patient switches rooms - and this happened with Carl. However, there are other times when the furniture gets moved because of painting/ repair work, and confusion occurs in the corridors when the furniture is returned. After one such move, Carl pulled the over bed table, and the top slid open to reveal the drawer below. It was filled with cosmetics and personal items that belonged to a woman who had been discharged months earlier. The staff couldn't figure out how this had happened.

8. The worst affront to the use of an over bed table is to use it as a stand for a urinal. This is the surface where trays are put for meals. It is the surface on which patients place newspapers, books, magazines, and treats from home. It is a surface on which they place their hands frequently - and few patients are able to wash their own hands without help - however - they use their hands to feed themselves. Carl was never offered a wash cloth to clean his hands before a meal when I was there - nor were his room mates.

9. The sink in the room is an interesting subject. Most of the care staff view them as filthy and don't use them except to fill a basin with water for bathing a patient or for emptying a water cup. They all use gloves in the room and never use the sink to wash their hands. However, the area around the sink is filled with lotions, mouthwash, and articles to support patient care. Is this area really that dirty/clean? I don't think that the sink is dirty because the cleaning staff washes it religiously - as they do the dispensers for liquid hand sanitizers. However, the staff did not maintain vigilant care of the equipment on or above the sink. Oxygen cannulas and and suction equipment were left for days without being cleaned or changed. I had to request that the suction equipment be cleaned as well as the oxygen cannula replaced.

10. Safety of equipment is questionable. Carl had three wheelchairs during his stay. The wheelchair on the Stroke Unit had one foot rest that worked and one that dragged on the floor. He was expected to use this for his two week stay on that unit. He was transferred to Rehab before this could be replaced. His first chair on rehab was adequate, but then he was given a wheelchair without foot rests so that he could "walk himself" around the unit. The tires on this wheelchair were so worn that the brakes did not work properly. This wheelchair moved with Carl to 4E. The staff would move Carl to the corridor in the morning after his morning care and breakfast and park him by the nurses' station. He would use his feet and move around the unit - whether the brakes were on or not. The Occupational therapist was aware of the inadequacies of the wheelchair, but a new one was never procured, despite the fact that I had completed all the paper work required for Blue Cross coverage before Carl left 3NE. (The delays were attributed to the wheelchair provider in Moncton) Not only did the brakes not work, but the handles of the brakes would come apart. They were attached by a cord, but Carl would pull it up and try to use it as a microphone - perhaps somewhat amusing, but hardly beneficial for braking the wheelchair.

11. A hospital is built to provide the care required to restore health, when possible. Health, today, is challenged by obesity. Selling chocolate bars on the ward clerk's counter on a stroke unit is counter productive to healthy eating habits. Family members are encouraged to provide water, juice, toast, etc. from the unit kitchens for the person they are visiting. It is interesting that children can't take peanut butter sandwiches to school, but peanut butter is readily available on the units where Carl stayed.

12. Bulletin boards are used on the units to convey important health messages to patients and family. It was interesting to enter the Stroke Unit on July 9th and see the bulletin board proclaiming that June is Stroke Month. On a unit where cognitive processes are assessed, it seemed to me that the board should have had a message with a current date. The white boards across from the beds were designed to have the staff members for the shift identified. The units rarely kept the boards current, which only added to the confusion of knowing who was caring for Carl and what their role was. This will be discussed later under Professionalism.

13. Maintenance was called several times to repair problems, and they were generally efficient and timely in their work. However, on one occasion the bed monitor was destroyed when the staff were pushing the bed back in to place. They explained to me that there were no more monitors on the unit. Carl was still at a point that he would try to get out of bed if he felt he needed to go to the bathroom or he wanted to get up. It was not safe for him to be in bed without one. I had to advocate for two days before one was brought from a different unit.

Details of Professional Issues

1. The major point of this "Case Study of Carl's Care" is to provide examples of deviations from best practices (safe care). The responsibility for correcting the problems that I identified lies with the senior administration of the Dr. Everett Chalmers Hospital. The level of morale within the hospital staff is at a critical low ebb on the units where Carl stayed. There were only three staff members whom I identified as unsafe and totally unacceptable within standard practice guidelines. The rest of the staff struggled to provide care without the help of experts in their areas of practice. The lack of a knowledgable resource nurse (head nurse or supervisor (in old fashioned terminology) created confusion in the delivery of care, errors in care, and frustration among the ever shifting rotation of caregivers. If the hospital is going to increase the numbers of personal care workers and licensed practical nurses on the Stroke Unit, Rehabilitation Unit and Transitional Care Unit, then it is absolutely imperative that a registered nurse with experience and passion for the care of patients on those units be hired to assist the support staff in providing competent care. The staff on the Rehab Unit appeared to be the most stable , but newer staff members had not all developed an understanding of the philosophy of that unit and the importance of engaging the patient and family in the care program. Many failed to understand the fact that patients and family members know important facts about how the treatments have and are effecting the health and safety of the individual for whom they are providing care.

2 Communication is always a challenge in any organization, and it was manifested within all the levels of professional care. Carl's primary care physician was Dr. Kevin Christie. Carl and I both appreciated his professional approach to Carl's care as well as his honesty about the challenges presented as his health deteriorated. Parkinson's Disease is not a "one size fits all" disease. Carl's symptoms were totally different from three of his UNB colleagues who were also struggling with the devastation of that disease. One of the facts that Dr. Christie stressed with us was that we were not to omit the medication (Sinemet) that he was taking and that once the dose was increased, it should not be decreased. When Carl was admitted to 3NE, he became a primary patient for another doctor. This doctor reduced his medication by 50%. Carl immediately developed more secretions as well as increased difficulty with swallowing - and consequently regurgitated food through his nose. It took several days before the nurses caring for Carl were able to explain to the doctor the increase in symptoms so that the medication was restored to the formerly prescribed amount.

3. Communication on 3NE was very clear regarding the process for Nursing Home Assessment. Because there didn't need to be a financial assessment for Carl's long term care, the process moved quickly, and he was approved for Nursing Home Admission on August 28, 2012. We were informed that he would be moved to 4E as soon as a bed was available and he would return to Dr. Christie for ongoing care, if required. He was moved to 4E on September 3, 2012. I was also informed that I would be charged a partial payment for his care on 4E until he was transferred to a nursing

home.

4. Orientation to 4E was sporadic, Because it is a locked unit, I was instructed carefully about leaving the unit. I was shown the kitchen area for fluids for Carl as well as the section in the utility room where tissues were kept - a necessity for Carl due to his increased secretions. I was not given a parking pass until the last week of Carl's stay on 4E. The Ward Clerk wasn't on when I arrived with Carl and she thought that I had one. It would be beneficial if units had an information sheet to give to family members so that they would "know the rules" of each unit.

5. Communication about rules regarding the patient dining room on 3NE and the dining rooms on 4E was inconsistent. It seems that the basic rule is that patients should eat in the dining room and family should not go with them. However, due to staffing issues and the issue of Carl's choking episodes, I was frequently encouraged to stay with Carl during meals. However, his choking episodes were unpleasant for many patients in the dining room, so it was not uncommon for us to be encouraged to stay in his room. He would have happily stayed in his room to eat all of his meals, but it was against "policy". It was also against policy for the nurses to take trays from the food carts and deliver them to the patients in the dining rooms. The carts are delivered, and there is a wait before the same staff return to unit to deliver the trays to the patients. The food was rarely warm when this policy was followed. Carl was given some type of "gravy" with most of his meals to enhance his ability to swallow. It is hard to make cold, gelatinous gravy appetizing or effective. The nursing staff need to supervise the dining rooms on 3NE and 4E to make sure that patients eat their meals and don't choke or experience other negative episodes. It is a time consuming job because many of the patients are not able to eat without encouragement or help or extra time. I am not sure that the staffing plans acknowledge this as well as the time it takes to porter patients to and from dining rooms and bathrooms.

6. Who is talking with me and who is taking care of Carl??? Name tags have been replaced by access cards that enable staff to enter the unit, med room, etc. Name tags are not worn on a uniform in a readable form - if at all. This is totally unprofessional and erodes self-esteem. Providers of care should be clearly identified. The white boards are not consistently used. Names may not be helpful to patients with dementia, such as Carl, but they are useful to family. If a medication is required, it is a waste of time to ask a personal care worker because she, in turn, then has to leave what she is doing and go to find the staff person who is appropriate. It is also important that the full name be visible. Many of the nurses on 4E share the same first name as another nurse. This makes sharing praise or reporting breaches of competent care difficult to enact. Unprofessional behaviors go unreported because not naming an employee gives the message that their accountability doesn't matter. An example of this follows: A family member arrived on 4E to stay with Carl for lunch and nap time. His room at that time was directly across from the Nurses" Station. When the family member entered the room, she found Carl on the floor with his head and one arm resting on the bed. (Fortunately, the bed was at floor level) She immediately went to the desk and asked the nurse who was sitting there to help her get Carl off the floor. Her response was, "He

is not my patient today". Carl's advocate said, "Perhaps you didn't hear me correctly - CARL IS ON THE FLOOR". The nurse then opined that she would find Carl's nurse. It took five minutes for a nurse to appear and get the help she needed to get Carl back in bed.

7. Medication administration is problematic for several reasons. Primarily it is difficult to avoid errors because the staff rotates so frequently that they don't know the patients well and the medicine order book is cumbersome. Medications were frequently given when patients were in the dining room (on 3NE and 4E). This made administration of medicines easier for the nurse, but it didn't always match the best time for the patient. Carl had several episodes of hypotension because his morning meds were given before he ate breakfast. Fortunately, the meds were usually given later, so that didn't occur too frequently. What did occur frequently was nurses questioning a physician's order because they didn't understand Carl's health challenges. Carl had gouty arthritis for the last 50 years of his life. It destroyed the bones in his feet to the extent that when he walked he was walking "bone on bone". Even "walking his wheelchair" for extended periods could produce serious discomfort. Small doses of Morphine Sulfate had been ordered PRN by the doctor. Many nurses were reluctant to bring the PRN med because they didn't think that arthritis needed more than tylenol. Negotiating pain control with an unnamed RN or LPN is a frustrating experience, particularly if that nurse did not note the rationale anywhere for a following nurse to see.

8. The absence of a qualified, interested senior nurse meant that well-meaning nurses were not assisted in providing an acceptable level of care. Seniors are complex - particularly seniors with dementias and overlapping chronic illnesses. One has to be curious and a bit of a detective to sort out what is causing a presenting symptom or problem. Three nurses were exemplary in trying to problem solve issues that arose in Carl's care because they identified the problem, asked me for information about my assessment of the changes, checked with resource materials and returned with suggestions for improved care. They would then check back to determine if it had helped. When the nurse left at the end of the shift,however, there was rarely follow through on the changes in care.

9. Carl's dietary needs were complex. He could eat a normal "house diet" because he didn't have issues with sugar or salt. However, he had major difficulties with swallowing. He was given a Barium Swallowing Test by Dr. Darren Clark in August. He confirmed that Carl was at risk of aspiration and that he should eat food with enough weight to help it get past the muscles in his throat that were not responding with enough vigour to move the food along safely. Chewing carefully (which he had always done) and eating slowing(always the last to finish a meal) were easy things for Carl to continue. He needed to eat small frequent meals rather than just three. High protein drinks were ordered, but these were usually given right before meals and served to depress his appetite. His inability to swallow became increasingly problematic and was a leading contender as a cause of his death. The dietitians were aware of Carl's problems, but their assigned hours for the unit were too few to help staff or family deal with the issues more constructively.

10. Competence in nursing care is evaluated, correctly or incorrectly, by families and visitors. One of Carl's care providers, who is not a nurse, went in to stay with Carl when he was on the stroke unit. Carl was in a wheelchair in his room by himself. He was slouched over and didn't respond to his name. The family member shook his shoulder and called his named. She pressed the buzzer for the nurse. When she came, the family member stated that it looked like Carl was having another little stroke. The nurse left the room without checking Carl and said, "I will check his blood work". She eventually returned with another nurse and they helped move Carl from the wheelchair to his bed. The family member was upset that the nurse hadn't gotten Carl into bed first and assessed him more thoroughly before checking the blood work.

11. When Carl was admitted to the hospital, he did not have a problem with incontinence. However, his dementia prevented him from being able to use the call bell. If his room mate was alert, he would call the nurses for Carl, but that wasn't always an option. Consequently, the nurses put disposable underpants on Carl and dealt with wet underwear when it occurred. Carl's dementia also prevented him from being able to use a urinal properly/consistently. Carl's mobility fluctuated. Sometimes, he could walk from the bed to the wheelchair by himself , whereas other times it took two or three nurses to move him to the wheelchair. By the last two months of his life, the staff usually used the standing lift or the sitting lift. There were two episodes that caused skin abrasions. One was acknowledged to me by one of the "good nurses", whereas the other incident was a "mystery". Fortunately, the skin barrier was not broken, but it took several weeks for the burn type of redness to subside.

12. "Basic care" should be a standard of care. Most men like to wash their hands and face, brush their teeth, and shave before beginning a day. The ritual of washing hands and cleaning teeth is usually repeated once again - if not twice during a day. Carl had a single tooth on a bridge and had two sets of eye glasses - one for reading and eating and the other for seeing his visitors and caregivers. The glasses cases were labeled. It was not uncommon for me to find Carl wearing the wrong glasses and to find that he either didn't have his bridge in - or if it was the end of the day - that it hadn't been cleaned at all. I gave Carl his manicures and pedicures. I know that the care staff are not allowed to cut the nails of patients with diabetes, but there is no reason why they can't make sure that the patients' hands are clean, including under their finger nails. There is also no reason why they can't use an emery board to shorten the nails. Carl's room mate asked me to trim his nails - and I happily did with an emery board. The women would get their nails "done" as part of the activity programme, but never the men. I often thought back to Hazel Chapman, the Infection Control Nurse, who kept us in line in the 1980s by checking the length of our fingernails and our hand washing techniques. The patients' hands and the staff's hands would never meet her standards!

13. After a discussion with me, Dr. Christie changed Carl's orders to reflect palliative care. The nurses on the unit that day were aware of the changes and were helpful about moving him to a private room. However, the transfer of information about Carl's care did not transfer across the shifts successfully. Carl was no longer able to swallow

and without Sinemet, he quickly became rigid. He couldn't swallow and his muscles were tight and it made moving him more difficult. I had to be away for 2 1/2 days, sadly, at this point, and when I returned, there was a significant change in Carl's abilities. Again, because of the frequent change in staffing and the confusion caused by the medication book, Carl had to wait for pain medication longer than reasonable until nurses were sent back to the medication book to check again for proper orders.

14. The nursing care staff did not seem to understand what was happening to Carl physiologically, so when he asked for the urinal, the nurse told me that he had just used it minutes before I arrived and he probably didn't need it. I asked her how much he urinated and she replied, "Not much". I asked that they check his bladder for retention, and it became clear that he had a significant amount of urine in his bladder (700cc). The nurse went to get permission to put in a catheter to provide comfort for Carl. She accepted an order for a straight catheter - which I didn't realize - because I had left the room while the catheter was being inserted. When I returned and discovered that he hadn't had a Foley catheter inserted, I asked to please get an order for one so that we wouldn't have to bother Carl with a straight catheter again. Neither she - nor the other care givers helping her - seemed to understand that he would not be regaining his ability to empty his bladder. This is a simple example of why a competent registered nurse should be available on each shift to help the new registered nurses, transfer nurses, licensed practical nurses,and personal care workers make best decisions for quality care.

15. Orientation of new staff to the unit is "brief". I am not sure of the process that is followed, but when a new nurse doesn't know how to turn off the call bell in the patient's room, one realizes that it wasn't thorough. Nurses would appear from Palliative Care or 3NE or sometimes one of the other 4th floor units to help when staffing was short. They did not know the patients well, and I will give credit to the regular staff for their efforts in helping the temporary staff make good decisions. However, it is lamentable situation to staff in this manner. It supports low morale.

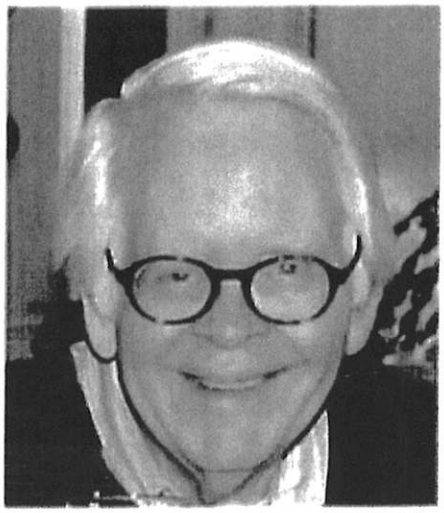
16. Another issue which increased anxiety and low morale was the issue of wearing masks during flu season. I asked to read a copy of the memo that was sent to the staff regarding the wearing of masks. It was signed with a name, but there were no identifying credentials next to the name. The letter was not written in a positive manner. I went to the hospital library and looked up the articles that were cited. They were not pertinent to the issues being discussed (TB was not an issue, US hospital rules don't govern Canadian hospitals, etc.) I served on the select committee chosen by the Council of Canadian Academies to evaluate the use of masks against the spread of influenza type illnesses. This report was requested by the Public Health branch of the Federal government. The type of masks provided for the nurses were not of a quality that would prevent the spread of influenza type illnesses - especially when more basic steps were not being taken - such as requesting that staff stay home when they are ill! The ward clerk on 4E was diligent about cleaning the telephone receiver during the daytime, but staff (from physicians to other hospital staff) rarely cleaned the phone. Emphasis should be on staying healthy rather than coming to work with the flu and

wearing a mask.

17. The inconsistent staffing patterns observed on the three units where Carl stayed are not unique. I have done pastoral care visiting for the last ten years, and it has been increasingly obvious that units are not occupied solely by patients identified for that area. I have visited many members of our church community on Pediatrics and their ages have ranged from 60 - 83. How difficult can this be for the nursing staff with experience in pediatrics?

18. There are many challenges facing health care delivery today. I would encourage the administration to work more closely with the NB Nurses Association and the NB Nurses Union to make it possible for competent nurses to be hired in positions that will strengthen the morale and caring abilities of the professional and nonprofessional nursing staff within the hospital. Magnet hospitals frequently pay "head nurses" the same wage as administrators because they know that the quality of care improves with consistent quality mentoring of staff. I would encourage you to work with the NB Medical Society to encourage them to work with their membership in improving communications between family physicians and specialists. I won't repeat the conversation with the physician who assessed Carl for nursing home care, but he was unprofessional and would benefit from a refresher course in assessment and communication skills.

Carl Ericson
1937-2013



Ericson, Carl

George Carl George Ericson died of Parkinson's Disease at The Dr. Everett Chalmers Hospital on Feb. 10, 2013. Carl was born in Westfield, Massachusetts on March 15, 1937.

He is survived by his wife, Penny, his four children: Braxton (Heidi Manzar) and Gregory (Nicole O'Bryne) of Fredericton; Juliana of London, England; Brian (Casey Ericson) of Yarmouth, Maine and his five grandchildren: Jacob, Kyle, Alexandra, Zachary, and Harper Ericson. He is also survived by his sister, Lee Krein (Bill Krein) of Quechee, VT and his brother-in-law Stanley King Jr. (Linda Waters) of Oakton, VA, and honorary family member Mary Saunders (George Saunders) of Mount Hope, NB.

Carl earned a PhD. from Queen Mary College (University of London, England). He moved from San Diego, California in 1966 to become a member of the History Department at the University of New Brunswick where he taught English Legal History, The History of The Tudor and Stuart, as well as, The History of Music. He retired from UNB in 1999.

Carl's avocation has always been music. He minored in music at the Eastman School of Music at The University of Rochester where he earned his Bachelors Degree. He augmented his knowledge of music as a Visiting Fellow at Harvard University. Although an organ scholar in his youth, he spent the majority of his life singing tenor. He studied with the Tanglewood Festival Chorus (home of the Boston Symphony Orchestra) for three summers and later moved to join The New Philharmonia Chorus in London, England. In NB, he spent eight years singing with the chorus in Lameque at the International Baroque Music Festival. In Fredericton, he was a steadfast member of the choir of Christ Church Cathedral. Carl's commitment to music included service with Community Concerts, Music on the Hill, and the NB Summer Music Festival.

Carl was an Officer of the Venerable Order of St. John and was awarded the St. John Ambulance Long Service Medal, as well as, the Queen Elizabeth Gold Jubilee Medal in 2003. He enjoyed the fellowship of The Fredericton Garrison Club and The Golden Club.

The family wishes to thank the caregivers at the Dr. Everett Chalmers Hospital, his physician, Dr. Kevin Christie, and Oli Surgenor, Jason Rudy and Andrew Cutler who helped Carl attain the strength he needed to maintain health with Parkinson's Disease for as long as possible.

Visitation will be held at McAdam's Funeral Home, 160 York St., on Friday, February 15th, from 2-4 and 7-9 pm. A memorial service will be held at Christ Church Cathedral on Saturday, February 16th, 2013 at 2 pm with The Very Reverend Keith Joyce officiating. For those who wish, donations in Carl's memory can be made to the Ericson Nursing Scholarship at UNB, Christ Church Cathedral Choir or the Music Program at Charlotte Street Art Centre.